STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING _____ B. WING _____	C 12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE HEALTH & REHABILITATION CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00161659 Complaint IN00161659-Substantiated. Federal/State deficiencies related to the allegations were cited at F323 and F385. Survey Dates: December 29, 2014 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Survey team: Regina Sanders, RN, TC Census bed type: SNF/NF: 73 Total: 73 Census Payor type: Medicare: 16 Medicaid: 42 Other: 15 Total: 73 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2.-3.1. Quality review completed on December 30, 2014, by Janelyn Kulik, RN.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		1/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/13/2015

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environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance devices to prevent accidents, related to a bed alarm not being turned on, and a resident attempted to transfer herself, and fell resulting in pain and a left orbital floor and medial orbital wall fractures (facial fractures). The resident had not been thoroughly assessed, which resulted in a delay of diagnostic testing to diagnose the fractures, for 1 of 3 residents reviewed for falls in a total sample of 3. (Resident #B)

Findings include:

During an interview on 12/29/14 at 2:55 a.m., RN #1 indicated Resident #B had a fall with an injury and the resident was in the hospital with an orbital fracture. RN #1 indicated Resident #B's roommate had activated the call light to alert the staff Resident #B had fallen. RN #1 indicated the resident had been found on the floor next to the bathroom floor by CNA #2 and CNA #2 had alerted her to the resident's fall. RN #1 indicated Resident #B had slight bleeding from the nose and had no signs of pain. RN #1 indicated the resident had been observed closely and when the resident's family came in approximately 30-40 minutes later, the resident showed signs of pain and was sent to the hospital. RN #1 indicated the resident had facial swelling and had been being treated for facial swelling with steroids prior to the

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fall. RN #1 indicated she was unsure if the resident's safety alarm had been activated.

During an interview on 12/29/14 at 3:13 a.m., RN #1 indicated the resident's fall was unwitnessed so neurological assessments were started on the resident. RN #1 indicated the resident was monitored every 15 minutes. RN #1 indicated when the resident's family came in the resident flinched when the family attempted to touch the resident's face. RN #1 indicated she paged the Resident's Physician and had not received a call back from the Physician. RN #1 indicated she had not attempted to page the Physician again. RN #1 indicated she did not think the resident needed to be sent out until the resident showed signs of pain. RN #1 indicated the resident had a, "little blood", from the nose, the resident's face was not deformed, and there was no bruising. RN #1 indicated the resident had facial swelling but the resident had swelling of the face prior to the fall.

Resident #B's record was reviewed on 12/29/14 at 4:17 a.m. The resident's diagnoses included, but were not limited to, dementia, difficulty walking and hypertension.

The 14-Day Minimum Data Set Assessment, dated 12/10/14, indicated the resident's decision making skill were severely impaired, required extensive assistance with one staff for transfers, had ambulated one time with one assistance in the past seven days, and had no falls.

A Fall Assessment, dated 11/26/14, indicated the resident had a high risk for falls, with a score of 13 (score over 10-high risk).

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A care plan, dated 11/26/14, indicated the resident had a potential for falls, the interventions included, 11/26/14-bed alarm.

A CNA Care Card, dated 12/12/14, indicated Resident #B had an alarm to the bed and the wheelchair.

A Physician's Order, dated 11/29/14 indicated an order for Medrol Pack (steroid), four milligrams as directed for facial swelling.

A Physician's Order, dated 12/03/14, indicated the resident was to have a chair and bed alarm.

A Physician's Progress Note, dated 11/28/14, indicated the resident had a possible medication reaction, which caused the facial swelling and the Vasotec (cardiac medication) had been discontinued and the resident was ordered a Medrol Pack.

A Nurses' Progress report, dated 12/06/14 at 5:42 a.m., indicated there was no facial swelling present.

The Weekly Skin Observation forms, dated 12/05/14, 12/09/14, and 12/12/14 indicated there was no facial swelling present.

There was no further documentation to indicate the resident had facial swelling from 12/12/14 through 12/16/14.

A Post Fall Note, dated 12/16/14 at 2:40 a.m., indicated the resident had a small amount of blood from the nasal area, had swelling of the left side of the face and eye area and had normal range of motion of the extremities.

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A Nurses' Note, dated 12/16/14 at 3:16 a.m., indicated, "...Observed resident on the floor next to the bathroom door in a sitting position...Resident able to move all limbs without difficulty. Small amount of blood from nasal area noted. Swelling to left side of face and eye area noted...Cleaned blood from nasal area...Left message for resident (Family Member Name)."

A Nurses' Note, dated 12/16/14 at 3:35 a.m., indicated, "Resident in bed asleep and easily aroused. No s/s (signs and symptoms) of hyper/hypoglycemia." There was no further assessment of the resident's facial swelling/injuries.

A Nurses' Note, dated 12/16/14 at 4:36 a.m. (one hour later), indicated, "Resident in bed awake and alert. Facial grimacing [sic] noted at this time. Resident is guarding left side of face. (Family Member Name) at bedside. Sending to (Hospital Name) ER (Emergency Room) for evaluation."

A Nurses' Note, dated 12/16/14 at 5:41 a.m. (three hours after the fall), indicated, "(Ambulance Name)...here to transfer resident...Facial grimacing [sic] noted at this time..."

The Neuro Check Form, dated 12/16/14, indicated a neurology assessment had been completed on 12/16/14 at 2:50 a.m., 3:50 a.m., and 4:50 a.m. with no changes in status.

There was a lack of documentation to indicate the resident had been assessed for increased swelling, bleeding, bruising, pain, and neurological status every 15 minutes as indicated by RN #1.

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A CT Scan of the facial bones, dated 12/16/14, indicated, "...Blowout fracture of the left orbital floor...Fracture also involves the medial wall of the left orbit. Possible nondisplaced fracture of the posterior wall of the left maxillary sinus. Blood in the left maxillary sinus."

A Hospital Otolaryngology consult, dated 12/17/14 at 1:04 p.m., indicated, "...Eye:...Left periorbital edema/ecchymosis (bruising)...Small but displaced orbital fractures. No surgical intervention is indicated..."

A Charge Nurse Fall Investigation, dated 12/16/14 at 3 a.m., indicated the cause of the fall was unknown. The intervention on the care card indicated bed alarm and mattress on floor. The investigation indicated the Nurse had not heard the alarm sounding due to the call light in the resident's room was on at the time of the fall and the staff were responding to the call light and observed the resident on the floor.

Further written investigation, received from the Director of Nursing (DoN) on 12/29/14 at 4:56 a.m., indicated CNA #2 responded to the call light and found the resident sitting on the floor. CNA #2 indicated the resident had received incontinent care around 12 a.m. CNA #2 indicated the resident was visual checked at 2 a.m. and the resident had been sleeping. CNA #2 indicated the bed alarm had not been activated.

During an interview on 12/29/14 at 5:39 a.m., the DoN indicated CNA #2 indicated to her the alarm had not been sounding and indicated she had not checked to ensure the alarm was on. The DoN indicated the alarm was checked for proper

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functioning the morning of 12/16/14 and the alarm when on, worked without problems. The DoN indicated she completed an audit on 12/20/14 (four days later) to ensure all alarms were on and functioning and provided education to CNA #2 for ensuring the alarms were turned on. The DoN indicated no other interventions were initiated to prevent others from being affected by not having their alarms on. The DoN indicated she was unaware the resident's Physician had not returned the call from the facility.

During a second interview with RN #1, on 12/29/14 at 6:32 a.m., RN #1 indicated she had attempted to call the resident's Physician first, then paged the Medical Director at 3:15 a.m. and left a message. RN #1 indicated the Physician's had not returned the calls to the facility by the time she left at 7 a.m. RN #1 indicated the resident had no open areas on her nose, and the blood had come from the nares. RN #1 indicated the resident had no further bleeding, had no signs of pain and did not feel the resident required an Emergency Room visit. RN #1 indicated the resident had been asleep after the fall and she had not checked the resident for an hour. RN #1 indicated the ambulance had not been called as a 911 call, so it did not respond immediately.

During an interview on 12/29/14 at 7:45 a.m., CNA #2 indicated the resident's alarm had not been activated. CNA #2 indicated the alarm was turned off. CNA #2 indicated she was unaware the resident had a bed alarm intervention and only saw the alarm when the Medics transferred the resident. CNA #2 indicated she had not seen nor checked the alarm during her shift (10:30 p.m. to 7 a.m.). CNA #2 indicated she had not

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F 323	Continued From page 7 looked at the care card for the resident's hallway. CNA #2 indicated the resident had a little bleeding from the nose and the left eye was swollen. CNA #2 indicated the resident had not exhibited pain at the time of the fall. This Federal Tag relates to Complaint IN00161659.	F 323		
F 385 SS=D	3.1-45(a)(2) 483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's Physician and the facility Medical Director responded to pages timely after attempts were made to contact the Physician and Medical Director, related to a fall, which the resident was transferred to the Emergency Room and diagnosed with facial fractures and complaints of pain for 1 of 3 residents reviewed for falls and physician notification in a total sample of 3. (Resident #B, Physician #3 and Physician #4)	F 385		1/13/15

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Findings include:

During an interview on 12/29/14 at 2:55 a.m., RN #1 indicated Resident #B had a fall with an injury and the resident was in the hospital with an orbital fracture (facial). RN #1 indicated Resident #B had slight bleeding from the nose. RN #1 indicated when the resident's family came in approximately, 30-40 minutes later, the resident showed signs of pain and was sent to the hospital. RN #1 indicated the resident had facial swelling.

During an interview on 12/29/14 at 3:13 a.m., RN #1 indicated when the resident's family came in the resident flinched when the family attempted to touch the resident's face. RN #1 indicated she paged the Resident's Physician and had not received a call back from the Physician. RN #1 indicated she had not attempted to page the Physician again.

Resident #B's record was reviewed on 12/29/14 at 4:17 a.m. The resident's diagnoses included, but were not limited to, dementia, difficulty walking and hypertension.

A Post Fall Note, dated 12/16/14 at 2:40 a.m., indicated RN #1 notified the Physician (no name given) on 12/16/14 at 3:15 a.m.

There was no further documentation to indicate the resident's Physician (Physician #3) had returned the call to the facility after being paged. There was no further documentation to indicate further attempts were made to contact the Physician #3.

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There was no documentation to indicate the facility's Medical Director (Physician #4) had been contacted when Physician #3 had not responded to the page from the facility.

A Nurses' Note, dated 12/16/14 at 4:36 a.m. (one hour later), indicated, "Resident in bed awake and alert. Facial grimacing [sic] noted at this time. Resident is guarding left side of face. (Family Member Name) at bedside. Sending to (Hospital Name) ER (Emergency Room) for evaluation."

A CT Scan of the facial bones, dated 12/16/14, indicated, "...Blowout fracture of the left orbital floor...Fracture also involves the medial wall of the left orbit. Possible nondisplaced fracture of the posterior wall of the left maxillary sinus. Blood in the left maxillary sinus."

During an interview on 12/29/14 at 5:39 a.m., the DoN indicated she was unaware the Physician #3 had not returned the page from the facility.

During a second interview with RN #1, on 12/29/14 at 6:32 a.m., RN #1 indicated she had attempted to call the Physician #3 first, then paged the Medical Director (Physician #4) at 3:15 a.m. and left a message. RN #1 indicated neither Physician #3 nor Physician #4 had returned the calls to the facility by the time she left at 7 a.m.

There was no further documentation in the resident's record to indicate Physician #3 and/or Physician #4 had returned the call to the facility from 12/16/14 3:15 a.m. through 12/16/14 at 5:42 p.m.

A facility policy, dated 08/08, received from the DoN as current, and titled, "Acute Condition

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F 385	Continued From page 10 Changes-clinical Protocol", indicated, "...5. The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response. 6. The Attending Physician...will respond in a timely manner to notification of problems or changes in condition and status. a. The staff will notify the Medical Director for additional guidance and consultation if a timely response is not received. The DoN or designee should also be notified..." This Federal Tag relates to Complaint IN00161659. 3.1-45(a)(2)	F 385		